BSBP EYE Report Form (for use by eye doctors when referring patients for services from the Bureau of Services for Blind Persons)

Bureau of Services for Blind **Persons**,
Michigan Dept. of Licensing and Regulatory Affairs

Patient/Client: _____

Address: _____

Phone: _____ Date of Birth: _____ Sex: M ☐ F ☐

BSBP Counselor (if known): _____

EYE EXAMINATION REPORT

NOTE TO EXAMINER
You are hereby authorized to release the information requested below to the Bureau of Services for Blind Persons. This exam is at the patient's expense unless this form is accompanied by a BSBP Service Authorization.

Patient/Client Signature: _____ Date: _____
(or Designee)

1. History

   A. Age at onset of significant visual defect:

   B. Injuries, infections, surgeries, hereditary factors:

2. Diagnosis:

   R.E.:

   L.E.:

3. Describe Abnormal Findings:

   R.E.:

   L.E.:

4. Intraocular Pressure in mm. Hg. (specify instrument used)

   R.E.:

   L.E.:

   Instrument:

5. Vision Measurements:

Without Correction:	Distance:	R.E.: 20/	L.E.: 20/
	Near:	R.E.: 20/	L.E.: 20/
With Correction:	Distance:	R.E.: 20/	L.E.: 20/
	Near:	R.E.: 20/	L.E.: 20/

Correction Needed:

R.E.: 20/ L.E.: 20/

Additional:

6. Peripheral Field of Vision: (Provide a verbal description of visual fields and attach copies of the charts, if available.)

7. Prognosis **(Check appropriate terms):** Patient's vision is considered:

☐ Stable ☐ Deteriorating ☐ Capable of Improvement ☐ Uncertain

8. Treatment Recommended:

9. Functional limitations caused by visual condition:

The following 3 criteria substantiate a disability for purposes of determining eligibility for rehabilitation services from the Bureau of Services for Blind Persons (please check all that apply):

☐ 1. Visual acuity in the better eye is 20/200 or less with best correction.
☐ 2. Visual fields are limited to subtending an angular distance not greater than 20 degrees.
☐ 3. Visual acuity is 20/100 or less in the better eye with a progressively worsening condition.

Examiner Information:

Name: _____

Address: _____

Examiner's Signature: _____ Exam Date:_____ Today's Date:_____

Please fax or mail completed form (with patient/client signature and examiner signature) to: Bureau of Services for Blind Persons, Fax 517-335-5140, 201 N. Washington Square, P.O. Box 30652, Lansing, MI 48909, or your local BSBP field office.

Authority: P.A. 260, as amended. Completion: Mandatory; Penalty: Non-payment of Service. BSBP/LARA is an equal opportunity employer/program. Alternative formats, auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.